

Name:

Department:

Day	Date	Temp (°F)	Symptoms		
0 (day exposed)		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough - occasional <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat (scratchy)	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
1		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough - occasional <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
2		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other: lymph node (left) in jaw slightly swollen
3		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
4		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
5		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
6		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
7		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:

8		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
9		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
10		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
11		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
12		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
13		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other:
14		AM: Temp: PM: Temp:	<input type="checkbox"/> No symptoms <input type="checkbox"/> Felt feverish <input type="checkbox"/> Cough <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chills <input type="checkbox"/> Headache <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Vomiting	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea: times/day <input type="checkbox"/> Other: